VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF TOBACCO USE

Guideline Summary

Update 2004

RECOMMENDATIONS WITH THE HIGHEST EVIDENCE: The highest evidence for recommendations is A, defined as "a strong recommendation based on randomized controlled trials that the intervention is always indicated and acceptable."

1. Patients should be asked about tobacco use at most visits, as repeated screening increases rates of clinical intervention. [R=A]
2. Tobacco users should be advised to quit at every visit because there is a dose response relationship between number of contacts and abstinence. [R=A]
3. Physicians should strongly advise tobacco users to quit, as physician advice increases abstinence rates. [R=A]
4. All tobacco users must have reasonable access to minimal counseling and to either an intermediate or intensive cessation program. [R=A]
5. Cessation treatment should include the following components:
   - Tobacco use cessation pharmacotherapy [R=A]
   - Counseling techniques that have been shown to be effective (problem solving, skill training, intra and extra treatment support) [R=A]
   - Multiple treatment sessions [R=A]
   - Multiple formats, proactive telephone counseling, and group or individual counseling [R=A]
6. Tobacco users who are willing to quit should receive some form of counseling. There is a dose response relationship between time spent in counseling and rate of abstinence. [R=A]
   - Minimal counseling (lasting <3 minutes) increases overall tobacco abstinence rates. [R=A]
   - Intensive counseling (>10 minutes) significantly increases abstinence rates. [R=A]
   - Multiple counseling sessions increase abstinence rates. [R=A]
7. Effective counseling can be delivered in multiple formats (e.g., group counseling, proactive telephone counseling, and individual counseling) and may be more effective when combined. [R=A]
8. Counseling should be provided by a variety of clinician types (physicians or nonphysician clinicians, such as nurses, dentists, dental hygienists, psychologists, pharmacists, and health educators) to increase quit rates. [R=A]
9. Tobacco users who are willing to quit may receive counseling via telephone Quitlines, as proactive telephone counseling has been demonstrated to be effective. Pharmacotherapy still needs to be coordinated by the primary care provider. [R=A]
10. Tobacco users attempting to quit should be prescribed one or more effective first-line pharmacotherapies for tobacco use cessation. [R=A]
    - First-line therapies include five nicotine replacement therapy (NRT) [transdermal patch, gum, nasal spray, lozenges, or vapor inhaler] and non nicotine replacement (bupropion IR or SR). [R=A]
    - Pharmacotherapy should be combined with minimal counseling (<3 minutes). [R=A]
11. Health care providers in a pediatric setting should advise parents to quit smoking to limit their children's exposure to second-hand smoke. [R=A]
12. Adolescents who use tobacco and are interested in quitting should be offered counseling and behavioral interventions that were developed for adolescents. [R=A]
13. All patients admitted to hospitals should have tobacco use status identified in the medical record. [R=A]
14. Tobacco users who are older should be given advice to quit. [R=A]
15. Tobacco users who are older should be given tobacco cessation treatment, including medication and counseling. [R=A]

VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.qmo.amedd.army.mil/pguide.htm

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VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF TOBACCO USE

Department of Veterans Affairs

Department of Defense

Update 2004

KEY ELEMENTS

1. **Every** tobacco user should be advised to quit.
2. Tobacco use is a **chronic relapsing condition** that requires repeated interventions.
3. Several **effective treatments are available** in assisting users to quit.
4. It is essential to **provide access** to effective **evidence-based** tobacco use **counseling treatments and pharmacotherapy**
5. **Collaborative tailored treatment strategies** result in better outcomes
6. Quitting tobacco leads **to improved health and quality of life**
7. **Prevention strategies** aim at reducing initiation, decreasing relapse, and eliminating exposure to environmental tobacco smoke

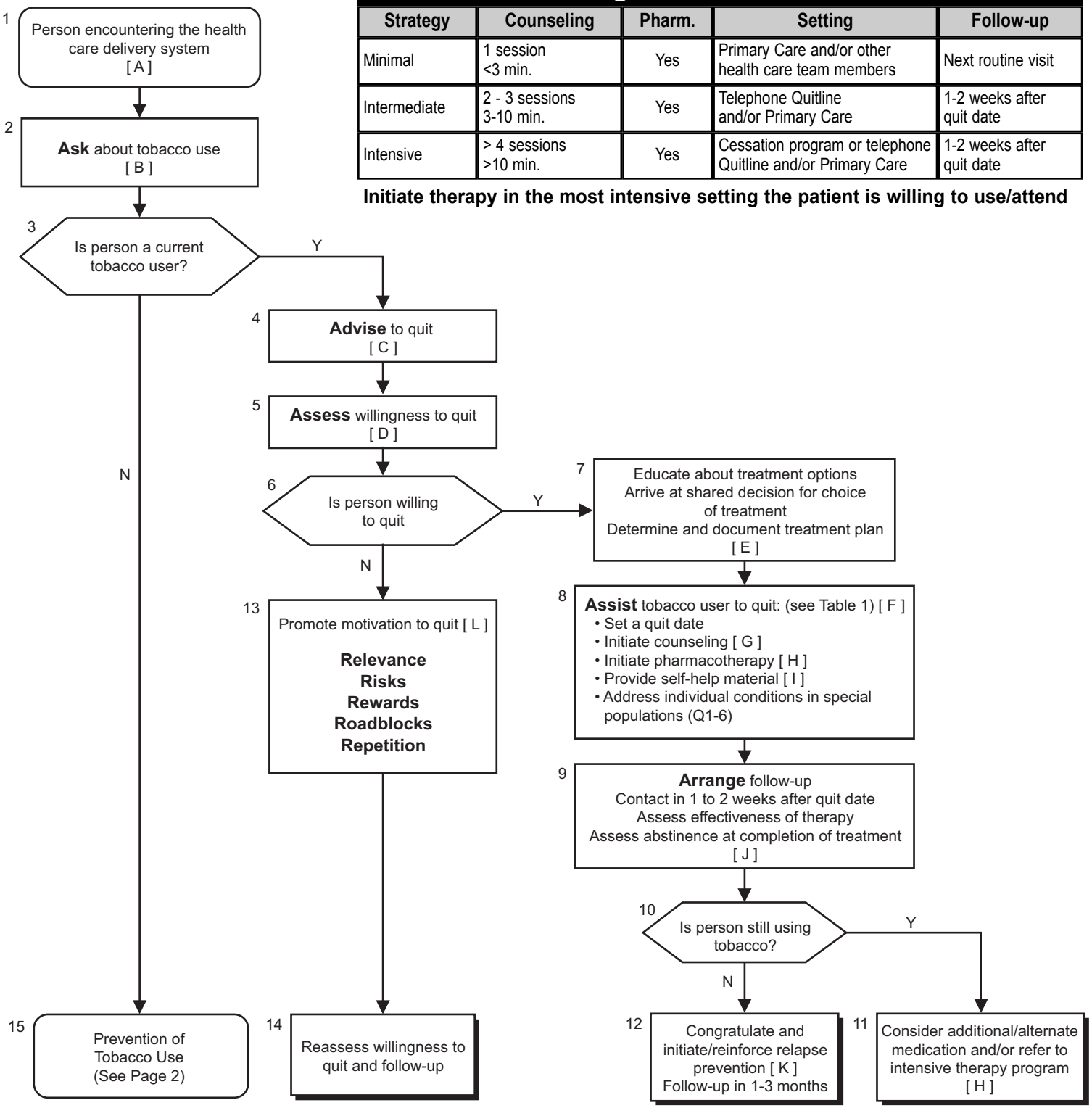
VA/DoD Clinical Practice Guideline for the Management of Tobacco Use

Assement and Treatment

Table 1: Strategies for Tobacco Use Cessation

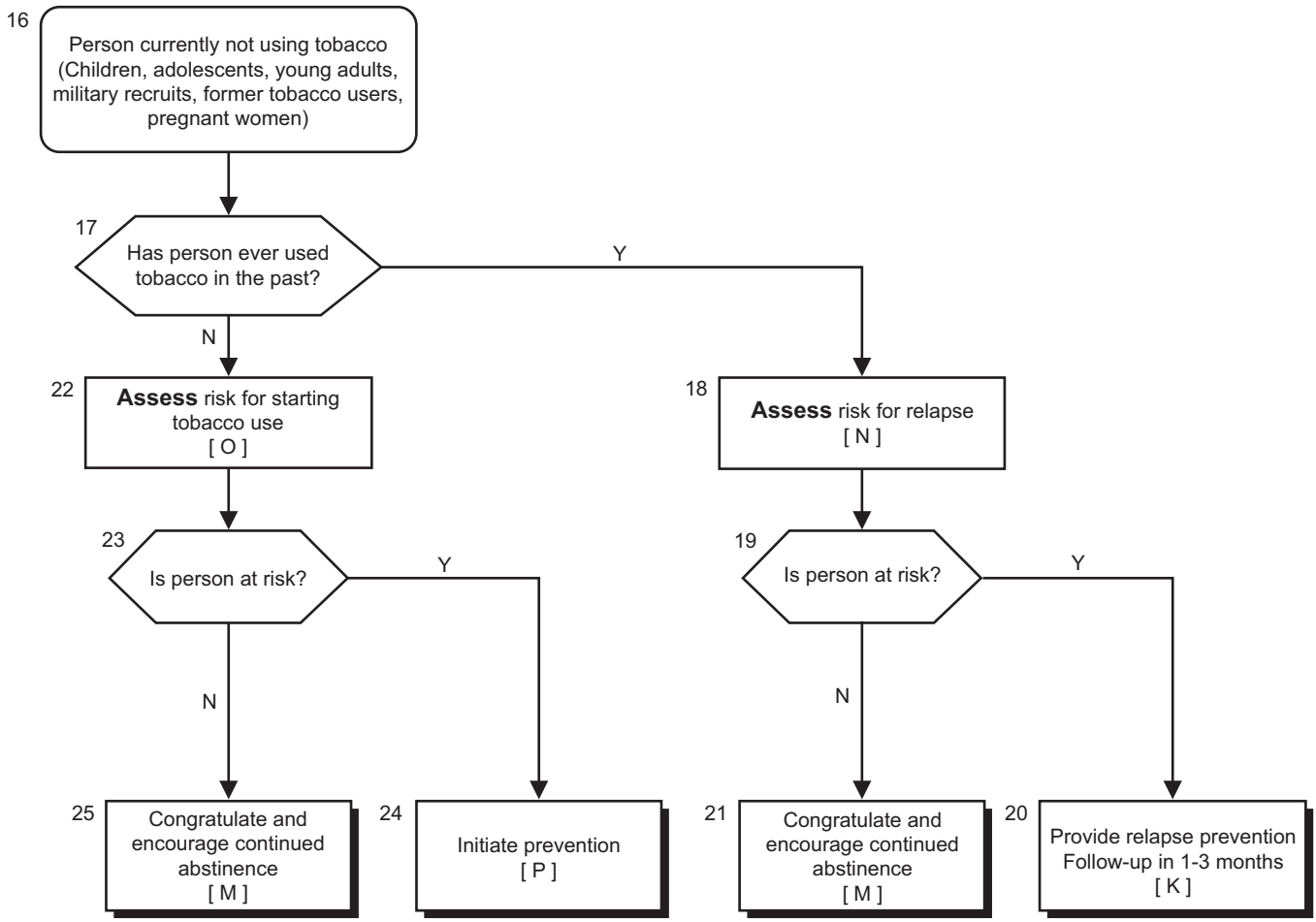
Strategy	Counseling	Pharm.	Setting	Follow-up
Minimal	1 session <3 min.	Yes	Primary Care and/or other health care team members	Next routine visit
Intermediate	2 - 3 sessions 3-10 min.	Yes	Telephone Quitline and/or Primary Care	1-2 weeks after quit date
Intensive	> 4 sessions >10 min.	Yes	Cessation program or telephone Quitline and/or Primary Care	1-2 weeks after quit date

Initiate therapy in the most intensive setting the patient is willing to use/attend



VA/DoD Clinical Practice Guideline for the Management of Tobacco Use

Prevention



ANNOTATIONS

ASSESSMENT AND TREATMENT

A. Person Encountering The Health Care Delivery System

Any person (age >12) who is eligible for care in the Veterans Health Administration (VHA) or the Department of Defense (DoD) health care delivery system should be screened for tobacco use as defined in this guideline.

B. Ask About Tobacco Use

OBJECTIVE

Identify tobacco users.

RECOMMENDATIONS

1. Patients should be asked about tobacco use at most visits, as repeated screening increases rates of clinical intervention. [A]
   - Screening for tobacco use in primary care should occur at least three times/year. [Expert Consensus]
   - Screening for tobacco use by other specialties or disciplines should be done at least once per year. [Expert Consensus]
   - Screening adolescents should include assessment of environmental tobacco exposure (see Annotation Q-1 – Children and Adolescents)

C. Advise to Quit

OBJECTIVE

Promote motivation to quit tobacco use.

RECOMMENDATIONS

1. Tobacco users should be advised to quit at every visit because there is a dose response relationship between number of contacts and abstinence. [A]
2. Physicians should strongly advise tobacco users to quit, as physician advice increases abstinence rates. [A]
3. Health care team members should strongly advise all tobacco users to quit. [B]

D. Assess Willingness To Quit

OBJECTIVE

Determine the individual's level of interest to quit tobacco use.

RECOMMENDATIONS

1. Tobacco users should be assessed for willingness to quit at every visit. [C]
   - Willingness to quit should be assessed at least three times/year. [Expert Consensus]

E. Educate About Treatment Options; Arrive At Shared Decision For Choice Of Treatment; Determine And Document Treatment Plan

OBJECTIVES

Provide the tobacco user who desires to quit choices and a variety of treatment modalities.

RECOMMENDATIONS

1. Providers and patients should discuss the range of available treatment options and arrive at a mutually agreeable treatment plan. Discussion should address [Expert Consensus]:
   - Individually relevant information regarding effectiveness, availability, suitability, and contraindications of different treatment options
   - Patient's individual preferences and concerns about the treatment options/combinations
   - Tailoring treatment for patients with special needs (pregnancy, adolescents, co-morbid conditions) (see Annotations Q1- 6 - Special Populations).
   - Choosing the most intensive treatment option that the patient is willing to use/attend.
2. Patient education and a treatment plan should be documented in the patient's record. [Expert Consensus]

F. Assist Tobacco User To Quit

OBJECTIVE

Initiate intervention to assist the tobacco user to quit tobacco use.

RECOMMENDATIONS

1. All tobacco users who are willing to quit should be offered an effective tobacco cessation intervention, including:
   - Pharmacotherapy
   - Counseling
   - Follow-up
2. All tobacco users must have reasonable access to minimal counseling and to either an intermediate or intensive cessation program. [A]
3. Cessation treatment may include the following components:
   - Tobacco use cessation pharmacotherapy [A]
   - Counseling techniques that have been shown to be effective (Problem solving, skill training, intra and extra treatment support) [A]
   - Multiple treatment sessions [A]
   - Multiple formats, proactive telephone counseling, and group or individual counseling [A]
   - Multiple types of counselors (e.g., physicians, psychologists, nurses, pharmacists, health educators) [B]
4. Aversive smoking interventions (rapid smoking, rapid puffing, other aversive smoking techniques) increase abstinence rates and may be used with smokers who desire such treatment or who have been unsuccessful using other interventions.[B] Although aversive smoking has been demonstrated to be effective, it is rarely used due to the availability of medication.
5. There is insufficient evidence to recommend for or against the use of the following interventions:
   - Acupuncture [C]
   - Hypnosis [C]
   - Physiological feedback and restricted environmental stimulation therapy[C]
   - "Harm reduction" products [C]
6. There is insufficient evidence to support the following strategies: relaxation/breathing, contingency contracting, weight/diet, cigarette fading, exercise and negative affect. Exercise may be considered to help prevent the weight gain associated with tobacco cessation. [I]

Table 1. Strategies for Tobacco Use Cessation

Each strategy should include pharmacotherapy, counseling, and follow-up. Ensure counseling and pharmacotherapy in the most intense setting that the patient is willing to use/attend and consider patient education materials.

Strategy	Counseling	Pharmacotherapy (e.g., NRT or buproprion)	Typical Setting (individual or group)	Follow-up
Minimal	1 session <3 min.	YES + Instructions print-out	Primary care provider *and/or* Other health care team members	Next routine visit
Intermediate	2 - 3 sessions 3 - 10 min.	YES + Instructions print-out	Telephone Quitline* *and/or* Primary care provider	1-2 weeks after quit date
Intensive	≥4 sessions >10 min.	YES + Instructions print-out	Cessation program *or* Telephone Quitline* *and/or* Primary care provider	1-2 weeks after quit date

**Medication may be prescribed by the primary care provider or other providers*

Minimal level of interventions can (should) be provided in the primary care clinic. The "minimal" refers only to the duration of counseling, not to its effectiveness. The intervention should include offering smoking cessation medications (either nicotine replacement therapy or bupropion) in conjunction with brief counseling (typically less than 3 minutes in duration). When possible, providers should follow-up with the patient 1-2 weeks after the quit date to assess tolerance to the medication and provide additional brief advice, as this further increases rates of successful smoking cessation.

Intermediate interventions typically include 2-3 sessions of advice, often for somewhat longer duration (3-10 minutes) than that of minimal interventions. This should also be in conjunction with the use of smoking cessation medications. Follow-up can be by the primary care provider, but given time constraints, many experts suggest other approaches to follow-up, such as proactive telephone counseling.

Intensive counseling can be delivered effectively in person or by telephone. Group or individual counseling is effective when it is provided by trained counselors and includes repeated contacts over a longer period of time. Intensive counseling includes several sessions (at least four session) of longer duration (10 minutes or more), making this requirement beyond what most primary care providers are able to offer. The efficacy of this approach increases as the amount of time spent with the patient increases. If the patient and provider chose the intensive strategy, which also includes medications and requires more specialized counseling, the provider should refer the patient to existing intensive cessation program. These programs are offered as group or individual face-to-face program, or proactive telephone programs (Quitlines). Referrals to an intensive program generally have the highest success rate with patients who choose to enroll and are motivated to attend. Many smokers cannot, or do not follow through with referral and the provider should follow-up with the patient after the referral to ensure that they are enrolled in the intensive intervention.

Patient Education Material: Smoking-cessation counseling strategies are also summarized in pamphlets and booklets, audiotapes, videotapes, and computer programs. Written self-help material may increase quit rates compared to no intervention, but the effect is likely to be small. While there is evidence that self-help materials are more effective than no intervention, there is no evidence that they offer any incremental benefit in patients who are receiving counseling and/or pharmacotherapy. Nevertheless, the working group consensus was to still recommend the use of self-help materials when feasible, for two reasons. First, the materials may have some effect in motivating smokers to make a quit attempt. Second, they save time for the provider, as he or she can provide brief counseling and then refer the patient to the self-help materials for additional details and advice.

G. Initiate Counseling

OBJECTIVE

Facilitate abstinence through counseling and behavioral interventions.

RECOMMENDATIONS

Counseling in the Clinic

1. Tobacco users who are willing to quit should receive some form of counseling. There is a dose response relationship in counseling and rate of abstinence. [A]
   - Minimal counseling (lasting <3 minutes) increases overall tobacco abstinence rates. [A]
   - Intensive counseling (>10 minutes) increases abstinence rates. [A]
   - Multiple counseling sessions increase abstinence rates. [A]
2. Effective counseling can be delivered in multiple formats (e.g., group counseling, proactive telephone counseling, and individual counseling) and may be more effective when combined. [A]
3. Counseling should be provided by a variety of clinician types (physicians or nonphysician clinicians, such as nurses, dentists, dental hygienists, psychologists, pharmacists, and health educators) to increase quit rates. [A]
4. All patients who are willing to quit should have access to intensive counseling (Quit lines or intensive cessation program).

Quitlines

5. Tobacco users who are willing to quit may receive counseling via telephone Quit lines, as proactive telephone counseling has been demonstrated to be effective. Pharmacotherapy still needs to be coordinated by the primary care provider. [A]

H. Initiate Pharmacotherapy

OBJECTIVE

Facilitate tobacco abstinence through pharmacotherapy to treat tobacco dependence.

RECOMMENDATIONS

1. Tobacco users attempting to quit should be prescribed one or more effective first-line pharmacotherapies for tobacco use cessation. [A]

- First-line therapies include five nicotine replacement therapy (NRT) [transdermal patch, gum, nasal spray, lozenges, or vapor inhaler] and non nicotine replacement [bupropion IR or SR]. [A]
- Pharmacotherapy should be combined with minimal counseling (<3 minutes). [A]
- Patient should be strongly advised not to use tobacco while using NRT
- Selection of an agent should be based on patient characteristics, relative contraindications, and patient preferences. [Expert Consensus]
- Typical duration for NRT is 8-12 weeks, and for bupropion 7-12 weeks [Expert Consensus]

2. Tobacco users who do not respond to first-line therapies should:
   - Continue the same agent for a longer duration
   - Switch to a different first-line agent or
   - Consider combination of two agents.
3. Combination therapy may be effective for patients unable to quit with a single first-line agent. [B]
   - Combining the nicotine patch with a self-administered form of NRT (gum or nasal spray) is more efficacious than a single form of NRT. [B]
   - There is some suggestive evidence for combining bupropion SR with NRT, but it is inconclusive. [B]
4. If patient has not responded after 2 courses of treatment, revaluate to assess the need of referral to intensive cessation program
5. Pharmacotherapies NOT recommended for tobacco cessation: antidepressants other than bupropion SR and nortriptyline; anxiolytics/benzodiazepines/beta-blockers; silver acetate; and mecamylamine.
6. Special consideration should be given to the potential risks versus benefits in the presence of special circumstances (e.g., adolescents, pregnant women, mental health comorbidity, and populations with special military duties). [Expert Consensus]
7. Patient who responded to therapy and successfully quit the use of tobacco and then relapsed should be treated in same manner as the initial therapy. (See also Annotation K – Initiate/Reinforce Relapse Prevention)
8. Insufficient evidence exists to recommend the use of extended pharmacotherapy for relapse prevention. [I]
9. Consider referral for intensive behavior modification counseling for tobacco users with multiple relapses. [Expert Consensus]

***First Line* - NRT**

Treatment of nicotine dependence with NRT should adhere to the three guiding principles of substance use disorder pharmacotherapy:

- Dose to effect - the initial dose should be sufficient to provide the patient with a nicotine dose similar to that seen prior to cessation of tobacco. Providers should always assess the patient's nicotine dependence before prescribing cessation aids.
- Treat withdrawal symptoms - the nicotine replacement dose should be sufficient to prevent or minimize craving for tobacco products.
- Avoid adverse reactions - the nicotine replacement dose should be small enough that signs and symptoms of over medication (i.e., headache, nausea, and palpitations) do not occur.

Five types of NRT products are available in the U.S. for pharmacological treatment of tobacco dependence.

1. Transdermal delivery system (patches)
2. Polacrilex resin (gum)
3. Polacrilex resin (lozenge)
4. Nasal spray
5. Oral vapor inhaler

***First Line* - NON-NRT**

There are a number of *factors to be considered* when determining whether a person desiring help in tobacco cessation would be a candidate for bupropion SR, including:

1. Nicotine dependence
2. Motivation to quit
3. Inability or disinclination to use nicotine replacement
4. Contraindicated drugs or disease states [e.g., seizures, alcohol dependency]

I. Offer Self-Help Material

RECOMMENDATIONS

1. Consider offering a variety of effective self-help educational materials to motivate and aid in the quitting process (e.g., pamphlets/booklets/mailings/manuals, videotapes, audiotapes, internet web pages, and computer programs). [Expert Consensus]

J. Arrange Follow-Up

OBJECTIVE

Develop a follow-up plan for patients interested in quitting tobacco use.

RECOMMENDATIONS

1. Tobacco users who receive a tobacco cessation intervention should be scheduled for ongoing follow-up for abstinence. [B]

   Follow-up should be documented and should:

   - Establish contact with the tobacco user 1 to 2 weeks after quitting date to assess abstinence [B]
   - Assess effectiveness of pharmacotherapy and appropriate use [Expert Consensus]
   - Assess for abstinence at the completion of the treatment and during subsequent clinical contact for the duration of at least 6 months [Expert Consensus]
   - Provide relapse prevention to tobacco users who remain abstinent (see Annotation K – Initiate/Reinforce Relapse Prevention)

2. Tobacco users who relapse should be assessed for willingness to make another quit attempt and offered repeated interventions (see Annotation D – Assess Willingness To Quit). [B]

3. Tobacco users should be tracked to increase the systematic delivery of interventions for tobacco cessation and increase the likelihood of long-term abstinence. [B]

PREVENTION

K. Initiate/Reinforce Relapse Prevention

OBJECTIVE

Prevent relapse to nicotine.

RECOMMENDATIONS

1. Relapse prevention should be addressed with every former tobacco user. [Expert Consensus].
2. Providers should address individual, environmental, and biopsychosocial factors associated with relapse. [Expert Consensus].
3. Providers should address weight gain after quitting as tobacco use cessation is often followed by weight gain. Consider bupropion SR or NRT, in particular, nicotine gum, which have been shown to delay weight gain after quitting.
4. Patients with multiple relapses or who are having trouble in a current quit attempt in a clinical setting should be directed to more intense counseling programs or medication should be adjusted. [B]

L. Promote Motivation To Quit

OBJECTIVE

Motivate tobacco users who are presently unwilling to quit tobacco to do so in the future.

Motivational strategies include, but are not limited, to the following:

- Avoid confrontation
- Remain neutral
- Acknowledge the tobacco user's ambivalence about quitting
- Elicit the tobacco user's view of the pros and cons of smoking and smoking cessation
- Correct the tobacco user's misperceptions about health risks of smoking and the process of quitting smoking
- Formulate an agenda – make it explicit
- Avoid conflict of agendas (e.g., "I can't talk to anybody" = "I can't talk to you.")
- Negotiate
- Summarize

RECOMMENDATIONS

1. Tobacco users who are not willing to quit at this time should receive brief, non-judgmental motivational counseling designed to increase their motivation to quit, to include discussion about [Expert Consensus]:
   - **R**elevance: connection between tobacco use and current symptoms, disease and medical history.
   - **R**isks: risks of continued tobacco use and tailor the message to individual risk / relevance of cardiovascular disease or exacerbation of preexisting disease.
   - **R**ewards: potential benefits for quitting tobacco use to their medical, financial, and psychosocial well-being
   - **R**oadblocks: barriers to quitting and discuss options and strategies to address patient's barriers.
   - **R**epetition: Reassess willingness to quit at subsequent visits; repeat intervention for unmotivated patients at every visit.
2. Use of motivational intervention should be considered. This technique has been shown to be beneficial in motivating and changing behaviors of individuals with other substance use dependencies, including some evidence in cessation of smoking. [B]

M. Congratulate And Encourage Continued Abstinence

OBJECTIVE

Congratulate non-users for changing a difficult behavior and encourage continued abstinence.

RECOMMENDATIONS

1. All tobacco non-users should be congratulated for not using tobacco ("Good for you") and advised to avoid initiation of tobacco. ("The single best thing you can do for your health is to avoid all tobacco products.") [B]

N. Assess Risk For Relapse

OBJECTIVE

Assess the risk for relapse for patients who have recently quit.

RECOMMENDATIONS

1. Tobacco users who have been abstinent for less than three months should be assessed for relapse. [B]
2. Tobacco users attempting to quit should be screened for a history of depression or a presentation of depressive symptoms predating the quit attempt as these factors strongly predict relapse. [B]
3. Psychosocial and environmental risk factors for relapse should be assessed to include: stress, depression, withdrawal symptoms, previous quit attempts, close presence of other tobacco users, history of substance use disorder and/or other risky behaviors. [C]
4. Patients who have relapsed should be assessed to determine whether they are willing to make another quit attempt. [C]

O. Assess Risk For Starting Tobacco Use

OBJECTIVE

Assess the potential for tobacco use in persons who have never used tobacco, based on existing risk factors.

RECOMMENDATIONS

1. Providers should ask non-users about their intention to smoke in the future, as this predicts the likelihood of initiation of tobacco use. [B]
2. Providers should be aware of the following risk factors for initiation of tobacco use in order to closely follow non-users with a proclivity toward initiation of tobacco use: [C]
   - Individual (e.g., low self-esteem, susceptibility to peer pressure, rebelliousness, depression, anxiety)
   - Family (e.g., family member who uses tobacco, especially parent, sibling, or spouse)
   - Educational level (e.g., less than 12 years of education, poor school performance, anticipated dropping out of school)
   - Societal/cultural/environmental (e.g., peers who use tobacco, exposure to tobacco advertising and products, white females with concerns of body image)
   - Military recruits (e.g., during special assignments with high stress or long periods of down time with access to tobacco)
3. Providers should be aware of the following protective factors that make tobacco use less likely: [B]
   - Individual (high self-esteem, assertiveness, social competence)

- Family (positive parental support, close communication with parents)
- Educational (school success, future goals)
- Social/cultural/environmental (nonsmoking peer group, social competence, strong sense of right and wrong, religious observance)

P. Initiate Prevention (Primary Prevention)

OBJECTIVE

Promote strategies that are most effective to prevent initiation of tobacco use among adolescents and young adults who have not started smoking (primary prevention).

RECOMMENDATIONS

1. Health care providers should be aware of, and support, community, and school-based tobacco prevention programs, as they are effective in the short-term. [B]
2. Health care providers who treat children, adolescents, and young adults should reinforce community prevention messages and may consider brief prevention interventions delivered in a developmentally appropriate manner. [C]

Q. Address Individual Conditions in Special Populations

Q-1. Children and Adolescents

OBJECTIVE

Describe unique issues relevant to the health care provider who comes in contact with children and adolescents.

RECOMMENDATIONS

1. Pediatric and adolescent patients and their parents should be screened by health care providers for tobacco use and provided a strong message regarding the importance of total abstinence from tobacco use. [Expert Consensus]
2. Health care providers in a pediatric setting should advise parents to quit smoking to limit their children's exposure to second-hand smoke. [A]
3. Health care providers in a pediatric setting should offer smoking cessation advice and interventions to parents to improve the parent's chance of quitting use of tobacco. [C]
4. Adolescents who use tobacco and are interested in quitting should be offered counseling and behavioral interventions that were developed for adolescents. [A]
5. Counseling and behavioral interventions shown to be effective with adults may be considered for use with adolescents. [Expert Consensus]
6. When treating adolescents, providers may consider prescriptions for bupropion SR or NRT when there is evidence of nicotine dependence and desire to quit tobacco use. [Expert Consensus]

Q-2. Pregnant Women

OBJECTIVE

Encourage all health care team members to advise pregnant tobacco users to quit and provide tobacco cessation treatment.

RECOMMENDATIONS

1. Refer to the VA/DoD Clinical Practice Guidelines for the Management of Uncomplicated Pregnancy.

Q-3. Military Recruits and Trainees

OBJECTIVE

Prevent relapse of basic trainees who quit using tobacco as a result of their participation in basic military training.

RECOMMENDATIONS

1. Relapse prevention should be addressed with every former tobacco user (see Annotation K – Initiate/Reinforce Relapse Prevention). [Expert Consensus]

Q-4. Hospitalized Patients

OBJECTIVE

Encourage all health care team members to advise hospitalized tobacco users to quit and provide tobacco cessation treatment.

RECOMMENDATIONS

1. All patients admitted to hospitals should have tobacco use status identified in the medical record. [A]
2. Tobacco users who are hospitalized should be given advice to quit. [B]

3. Tobacco users who are hospitalized should be given tobacco cessation treatment, including medication and counseling. [B]
4. Whenever possible, augmented smoking cessation treatment should be provided to tobacco users who are hospitalized. [Expert Consensus]
5. Tobacco users should be referred for continuing treatment and support upon discharge. [Expert Consensus]

Q-5. Older Patients

OBJECTIVE

Encourage all health care team members to advise older tobacco users to quit and provide tobacco cessation treatment.

RECOMMENDATION

1. Tobacco users who are older should be given advice to quit. [A]
2. Tobacco users who are older should be given tobacco cessation treatment, including medication and counseling. [A]
3. There are insufficient data to support or refute variations on smoking cessation interventions among the elderly. Assessment and treatment of tobacco users who are older should follow the recommendations included in the guideline. [I]

Q-6. Psychiatric/Mental Health Patient

OBJECTIVE

Provide effective tobacco cessation services to patients with psychiatric comorbidities.

RECOMMENDATIONS

1. Tobacco users with comorbid psychiatric and substance abuse conditions should be provided tobacco cessation treatment. [B]
2. Tobacco users receiving treatment for chemical dependency should be provided tobacco cessation treatments to include counseling and pharmacotherapy. [C]
3. Tobacco users with other comorbidities may have a low rate of successful treatment. The optimal treatment for tobacco users with current/past depression is uncertain, but they may require longer and more intensive treatment. [B]

DRUG DETAILS TABLE PRIMARY CARE**

Agents	Sample Regiments	Typical Duration	Common Adverse Effects
Nicotine Replacement Therapy (NRT)			
Transdermal patch[1,3] **24 hr (e.g., Nicoderm® CQ)** **(may be worn for 16 or 24 hours)**	High dependence*: 21mg patch for 4-6 weeks, then 14mg patch for 2 weeks, then 7mg patch for 2 weeks Low dependence* 14 mg patch for 6-8 weeks, then 7mg patch for 2 weeks	8 – 12 weeks	• Sleep disturbance • Local irritation • Bone pain • Headache • Nausea
Nicotine polacrilex gum[1,3]	High dependence*: 4 mg gum every 1-2 hours for 6 weeks then every 2-4 hours for 4 weeks then every 4-6 hours for 2 weeks Low dependence* 2 mg gum every 1-2 hours for 6 weeks then every 2-4 hours for 4 weeks then every 4-6 hours for 2 weeks	8 – 12 weeks	• Local mouth irritation • Jaw pain • Rhinitis • Nausea
Nicotine polacrilex lozenge[3]	High dependence*: 4 mg Low dependence*: 2mg Suck 1 lozenge every 1-2 hours for 6 weeks then 1 every 2-4 hours for 3 weeks then 1 every 4-8 hours for 3 weeks	8 – 12 weeks	• Local mouth irritation • Headache • Nausea • Diarrhea • Flatulence • Hiccup • Heartburn • Cough
Vapor inhaler (Nicotrol® Inhaler)	Inhale deeply or puff on cartridge for about 20 minutes (delivered dose 4mg/cartridge) Use 6-16 cartridges a day for 6 weeks then 4-8 cartridges a day for 2 weeks then 2–6 cartridges a day for 2 weeks	8 – 12 weeks	• Local irritation • Cough • Rhinitis • Headache • Dyspepsia
Nasal spray (Nicotrol® NS)	1 spray in each nostril = 1 dose (0.5mg each, 1 mg total) Use 1–2 doses/hr up to a maximum of 40 doses per day (80 sprays) for 6 weeks then 1-2 doses every 2-4 hours up to a maximum of 20 doses per day (40 sprays) for 2-4 weeks then 1 dose every 4-6 hours for 2 weeks	8 – 12 weeks	• Headache • Nausea • Confusion • Palpitations • Nasal irritation
Non-Nicotine Therapy (NNT)			
Sustained-release bupropion[1,2]	150 mg/day for 3 days, then 150 mg twice a day	7 – 12 weeks	• Anxiety • Disturbed concentration • Dizziness • Insomnia • Constipation • Dry mouth • Nausea
Bupropion IR[1]	100 mg/ day for 3 days, then 100 mg three times a day to complete 7-12 weeks	7 – 12 weeks	

* *High dependence definition varies based on manufacturer's labeling and expert consensus. In general, use of tobacco greater than or equal to 20 cigarettes (one package) per day are considered high dependence or use of tobacco less than 30 minutes after awakening. If these criteria do not apply the patient is consider low dependent.*

***For complete drug information, refer to manufacturer's drug information sheets.*

1 Currently on formulary in the VA

2 Currently on basic core formulary in the DoD, may be available on local formulary

3 Available over the counter

Contraindications/ Relative Contraindications

Relative Contraindications to Nicotine-Replacement Therapy

- Hypersensitivity
- Pregnancy: Category D
- Coronary artery disease (within 14 days post myocardial infarction)

Contraindications to Non-Nicotine Therapy (bupropion)

- History of seizures
- Predisposition to seizures
- Recent Stroke
- Severe head trauma
- Abrupt withdrawal from heavy, daily alcohol or other sedative
- MAO inhibitor within 14 days
- Bulimia, anorexia nervosa

Relative contraindications to Non-Nicotine Therapy (bupropion):

- Hypersensitivity
- Pregnancy: category B

Key Points For Using NRT and NNT Agents:

1. Miscellaneous conditions – Use of NRT must be carefully assessed and monitored in persons with hyperthyroidism, peptic ulcer disease, insulin-dependent diabetes mellitus, TMJ syndrome (nicotine gum), severe renal impairment, and certain peripheral vascular diseases.
2. Nicotine from any NRT product may be harmful to children and pets if taken orally.
3. Unstable coronary artery disease – NRT is relatively contraindicated in persons with unstable coronary artery disease.
4. Stable coronary artery disease – NRT can be initiated at intermediate doses with careful monitoring.
5. Pregnancy – The U.S. Food and Drug Administration (FDA) has developed a uniform warning for all non-prescription NRT. They warn against the risks of nicotine in pregnancy. They believe that NRT is safer than smoking in pregnancy; however, the risk to the fetus from this medicine in not fully known. The risk of fetal harm due to nicotine must be weighed against the benefit of abstinence from tobacco.
6. Geriatrics – The safety of NRT in the elderly has not been systematically evaluated. However, one small pharmacokinetic study concluded that though there were statistically significant differences, the disposition of nicotine does not seem to be changed to a clinically important extent in the elderly compared to younger subjects.

General

Adolescents are usually not addicted to nicotine and therefore are not usually candidates for NRT. However, NRT may be considered in adolescents with nicotine dependence and willingness to quit.

Oral forms

Do not eat or drink for 15 minutes before, during or after using.

Gum

Chew (gently) until a peppery taste, and then park between teeth and gums to facilitate nicotine absorption through the oral mucosa. Gum should be chewed slowly and intermittently "chewed and parked" for about 30 minutes or until the taste dissipates. No more than 24 pieces per 24 hours.

Lozenge

Place in mouth and allow to dissolve slowly over 20-30 minutes. Do not chew or swallow. Consuming too quickly may cause heartburn and nausea. Shift in mouth occasionally. No more than 5 in 6 hours or 20 per 24 hours. Tingling feeling in mouth on release of medication is normal and expected.

Nasal Spray

Patients should not sniff, swallow, or inhale through the nose while administering doses as this increases irritating effects. The spray is best delivered with the head tilted slightly back.

Inhaler

Delivery of nicotine from the inhaler declines significantly at temperatures below 40°F; do not eat or drink for 15 minutes before and after using.

Bupropion

May be considered in adolescents with nicotine dependence and willingness to quit.

APPENDIX A-6:
PRIMARY PREVENTION IN YOUNG ADULTS AND ADOLESCENTS

Suggested focused interventions for Primary Care providers to prevent initiation of tobacco use include the following:

Elementary School (through 6th grade):

1. Ask the child if he or she has experimented with tobacco.
2. Reinforce positive health choices.
3. Provide anticipatory guidance regarding the likelihood that he or she may encounter peers who use tobacco and discuss ways in which he or she might address peer pressure to try tobacco.

Middle School and High School (7 to 12th grade):

1. Reassure that most kids do not use tobacco.
2. Educate that all forms of tobacco (including snuff, cigarettes, dip, etc.) are equally dangerous and extremely addictive, and once you are hooked, it is very hard to quit.
3. Readdress issues of peer pressure.
4. Introduce the idea that addiction to tobacco takes away one's independence.
5. Point out that tobacco use leads to:
   - Bad breath
   - Brittle and smelly hair
   - Smelly clothes
   - Stained teeth and finger nails
   - Stained and burned clothes
   - More colds, shortness of breath, and minor illnesses
   - Decreased athletic performance
   - Fire and deaths
6. Tobacco companies market to teenagers that smoking is rugged, sexy and cool. Eighty-five percent of all teenagers say they would prefer a boyfriend or girlfriend who does NOT smoke.
7. Addiction to nicotine may make a person more susceptible to trying other dangerous drugs.
8. The rule of 4s: There are over 4000 chemicals in every cigarette; 400 are toxic, at least 40 are known to cause cancer, and they are the same chemicals as are found in dead bodies (formaldehyde), moth balls or urinal cakes (naphthalene), gas chambers (hydrocyanide), fertilizer (phosphatides), and decaying fish (methylamine).